Prisons & Probation
Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Damion Mellor a prisoner at HMP Leicester on 13 January 2019

**A report by the Prisons and Probation Ombudsman**

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## Our Vision

**To carry out independent investigations to make custody and community supervision safer and fairer.**

## Our Values

**We are:**

**Impartial:** *we do not take sides*
**Respectful:** *we are considerate and courteous*
**Inclusive:** *we value diversity*
**Dedicated:** *we are determined and focused*
**Fair:** *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Damion Mellor was found lying in his bed in his cell with a ligature around his neck at HMP Leicester on 12 January 2019. He died of a brain injury caused by a lack of oxygen to the brain the following day in hospital. He was 33 years old. I offer my condolences to his family and friends.

Prison staff at Leicester were not aware of any indications that Mr Mellor was at risk of suicide, including in the days before his death, and I do not therefore consider that they could reasonably have predicted his actions. I am concerned however that an opportunity was missed to assess whether his risk to himself had increased after a police interview just days before his death.

Mr Mellor had smoked psychoactive substances (PS) before his death. Although this did not directly contribute to or cause his death, PS is known to affect mood and mental health adversely. I am concerned that Mr Mellor was able to obtain PS with apparent ease at Leicester and the prison needs to continue in its efforts to reduce the supply of and demand for drugs.

The clinical review into Mr Mellor's death concluded that his care was not equivalent to what he might have expected in the community. I am concerned that when Mr Mellor referred himself to the mental health team, it was not actioned; that mental health action plans were not adequately recorded; and that Mr Mellor was not told about a re-scheduled mental health appointment.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Sue McAllister CB**
**Prisons and Probation Ombudsman** **September 2019**

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# Summary

## Events

1. On 17 August 2018, Mr Damion Mellor was remanded to HMP Leicester, charged with assault. It was not his first time in prison.

2. Mr Mellor had a history of depression, which had been treated with antidepressants, and had reported anxiety during previous periods of custody. There was intelligence that Mr Mellor used psychoactive substances (PS) and that illicit drugs and mobile phones had been found in his cell during previous prison sentences. Mr Mellor had last been monitored under suicide and self-harm monitoring procedures, known as ACCT, in February 2016.

3. A nurse from the mental health team assessed Mr Mellor on 3 September 2018 and referred him to the prison GP, but made no further plans. On 31 October, Mr Mellor referred himself to the mental health team and asked to speak to a named nurse. The referral was returned to him as the nurse no longer worked at the prison.

4. On 10 January 2019, police questioned Mr Mellor about allegations that he had perverted the course of justice. The timing of the interview meant that he missed an appointment with the prison's psychological wellbeing practitioner. Although a further appointment was made subsequently, he was not told about it.

5. At around 1.47pm on 12 January, an officer found Mr Mellor lying in his bed, with a ligature tied around his neck. Staff and paramedics responded promptly and resuscitated him. He was transferred to the hospital where he died the following day. Post-mortem toxicology tests showed that Mr Mellor had PS in his system when he died.

## Findings

6. We found no evidence that prison staff could have known that Mr Mellor was at risk of suicide. We do not therefore consider that they could reasonably have predicted his actions.

7. We are concerned about the continued availability of PS at Leicester.

8. The clinical review was not satisfied that the healthcare Mr Mellor received was equivalent to that he could have expected in the community. She is concerned that mental health staff failed to consider or note action plans in Mr Mellor's medical records and that there were deficiencies in the mental health team's self-referral process.

9. Staff failed to assess Mr Mellor after police questioned him. This was a missed opportunity to identify any increased risk. Mr Mellor missed a psychological assessment which was at the same time as his police interview. Although it was rescheduled, he was not told about the new appointment.

## Recommendations

- The Governor should ensure that the key drug issues at Leicester are identified and that the prison's local drugs strategy is revised by September 2019 to address these issues.
- The Governor and Head of Healthcare should ensure that prisoners returning from police questioning, court appearances or other temporary absences are screened to assess their risk of suicide or self-harm.
- The Head of Healthcare should ensure that all healthcare staff reviewing or assessing prisoners make accurate notes of their interactions and record care plans and other actions clearly.
- The Head of Healthcare should ensure that when prisoners refer themselves to the mental health team, mental healthcare staff do not return incomplete or unclear applications without first assessing the urgency of and reasons for the referral.
- The Head of Healthcare should review the system for notifying prisoners of rearranged appointments for their clinical services and consider early notification to alleviate anxiety about missed appointments.
- The Governor and Head of Healthcare should ensure that a copy of this report is shared with members of staff so that they are aware of the Ombudsman's findings.

# The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Leicester informing them of the investigation and asking anyone with relevant information to contact him.

11. The investigator visited Leicester on 25 January 2019. He obtained copies of relevant extracts from Mr Mellor’s prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Mellor’s clinical care at the prison.

13. The investigator interviewed 13 members of staff and four prisoners, some jointly with the clinical reviewer.

14. We informed HM Coroner for Leicester City and South District of the investigation. We have sent the Coroner a copy of this report.

15. We contacted Mr Mellor’s parents to explain the investigation. They had no specific questions but asked if their son used PS before his death.

16. Mr Mellor’s parents received a copy of the initial report. They did not make any comments.

# Background Information

## HMP Leicester

17. HMP Leicester is a local prison that holds 325 men. The prison serves the courts of Leicestershire, Derbyshire, Northamptonshire and Nottinghamshire. Nottinghamshire Partnership NHS Trust provides healthcare services at the prison.

## HM Inspectorate of Prisons

18. HM Inspectorate of Prions (HMIP) carried out an unannounced inspection of Leicester in January 2018. Inspectors found significant improvement across many areas since their last inspection in 2015. Inspectors reported that staff were more visible, confident and friendly and prisoners in crisis reported that they felt supported by staff. HMIP congratulated the governor and staff at the prison about the progress achieved since their last inspection.

19. However, inspectors raised concern that PS remained a threat to stability. Although there were good initiatives to address this, efforts to reduce the supply of drugs were not effective enough. Inspectors made a recommendation about drug supply reduction.

20. Inspectors reported that healthcare services had improved, although clinical records did not always contain a mental health care plan or report regular nursing reviews.

## Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year ending January 2018, the IMB reported good liaison between safer custody and the mental health team. The IMB reported that the experience of prisoners continued to improve in most areas and that there were good supportive and constructive interactions between staff and prisoners.

## Previous deaths at HMP Leicester

22. Mr Mellor was the third prisoner to take his life at Leicester since October 2017. There was no similarity between the previous deaths and that of Mr Mellor.

## Assessment, Care in Custody and Teamwork (ACCT)

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Psychoactive substances (PS)

24. PS (formerly known as ‘new psychoactive substances’ or ‘legal highs’) are a serious problem across the prison estate. They are difficult to detect and can affect people in many ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

25. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.

26. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

# Key Events

### Background

27. Mr Damion Mellor had served several previous sentences for assault and drug offences, including at HMP Nottingham. Intelligence reports submitted between 2012 and 2015, noted his involvement in the use and trading of drugs and mobile phones.

28. Mr Mellor was last monitored under ACCT procedures in February 2016. During periods of custody between 2012 and 2018, he reported poor sleep and appetite, anxiety and low mood. He was diagnosed with depression and prescribed antidepressants.

29. In the summer of 2017, Mr Mellor told staff that he needed a single cell for mental health reasons. He said that he had been attacked two years earlier and feared for his safety. He reported that his anxiety had reduced after he was given a single cell. Mr Mellor missed several mental health appointments in 2017. He was discharged from the care of the mental health team in early 2018 because he did not engage with them.

30. Numerous intelligence reports submitted at Nottingham in the first half of 2018 noted that Mr Mellor was receiving illicit items during prison visits and had been found in possession of illicit drugs, including PS, and it was thought that he got other prisoners to hold illicit items on his behalf. On at least two occasions, drugs and mobile phones were found in his cell.

31. On 10 August, Mr Mellor was released from Nottingham.

### HMP Leicester

32. On 17 August, Mr Mellor was charged with assault and remanded to HMP Leicester.

33. A nurse completed an initial health screen. Mr Mellor told the nurse that he had previously taken antidepressants but he denied thoughts of suicide or self-harm. The nurse referred him to the mental health team for further assessment. (The mental health team accepted the referral on 23 August.)

34. A member of staff from the prison's substance misuse support team told Mr Mellor about the dangers of using PS and other drugs in prison. Mr Mellor told her that he had no substance misuse issues and did not want to engage with the team.

35. An officer completed a first night interview. Mr Mellor said that he had spent time in Leicester before, was aware of the prison regime and had no issues. Mr Mellor told a prison chaplain, that he was a Rastafarian, was interested in faith services and expected to receive visits in prison.

36. On 28 August, Mr Mellor's mother telephoned the prison and left a message to say that she was concerned that she had not heard from her son since he arrived at the prison. Staff told Mr Mellor that his mother was concerned about him and gave him the opportunity to contact her. (Telephone records note that Mr Mellor spoke to his parents twice on 22 August.)

37. On 30 August, Mr Mellor received a visit from a friend.

38. On 3 September, a learning disability nurse in the mental health team, assessed Mr Mellor. She noted his history of anxiety and low mood. Mr Mellor told the nurse that he had previously been prescribed antidepressants which made him feel calmer and helped him sleep but he said he had stopped using them as he felt "silly" taking them. Mr Mellor told the nurse that he found it difficult to talk but felt better knowing that somebody was "looking out for him", asking if he was okay. She noted that Mr Mellor had moderate depression and would "appreciate emotional support". Mr Mellor denied thoughts of suicide or self-harm. The nurse referred him to a prison GP, with a view to re-prescribing antidepressants.

39. The nurse told the investigator that she also made plans for a healthcare support worker to check on Mr Mellor occasionally to offer emotional support. She did not note this in his medical record.

40. Mr Mellor appears to have settled quickly at Leicester. He caused few concerns to staff, he was compliant with the prison's regime and he applied for work.

41. Intelligence in early September indicated that Mr Mellor might have been trying to retrieve illicit drugs. On 10 September, when staff assessed his risk of sharing a cell, he refused to share a cell. His risk was assessed as high and he stayed in a single cell. A further review was scheduled for the following month.

42. On 10 September, Mr Mellor missed his GP appointment, at which his need for antidepressants was to be reviewed. The reason for his non-attendance was not noted.

43. On 11 September, a mental health nurse saw Mr Mellor. The nurse noted that Mr Mellor had no thought disorder or signs of psychosis and that he had previously been prescribed antidepressants. Soon afterwards, Mr Mellor told a prison GP that he did not socialise much with other prisoners but that this was normal for him, and he preferred to be alone. Mr Mellor denied thoughts of suicide or self-harm although the prison GP noted that he had self-harmed some years earlier. The prison GP re-prescribed antidepressants and scheduled a review of his medication in four weeks.

44. On 15 September, Mr Mellor's friend visited him again. On 20 September, intelligence was submitted which noted that his visitor had previously brought drugs into HMP Nottingham during a visit. The issue was highlighted to staff.

45. On 29 September, Mr Mellor received a third visit from his friend. During the visit he was challenged for inappropriate behaviour, and was asked to move his chair away from her. Mr Mellor was searched at the end of the visit. Nothing was found and it was noted that he was not happy that his behaviour had been challenged.

46. On 9 October, a prison GP reviewed Mr Mellor's antidepressants. Mr Mellor told her that he was slowly feeling the benefits of the medication, which he wanted to continue and had no thoughts of suicide or self-harm. His medication was continued.

47. On 31 October, Mr Mellor referred himself to the prison's mental health team, and asked to speak to a nurse called "NAME". A psychological wellbeing

practitioner, returned the referral to Mr Mellor and said that the nurse no longer worked at the prison and that Mr Mellor should submit a new self-referral to explain his specific problem.

48. On 2 December, Mr Mellor received another visit from his friend.

49. On 8 December, when staff reassessed his risk of sharing a cell, Mr Mellor continued to refuse to share a cell.

50. On 10 December, an officer introduced himself to Mr Mellor as his key worker. (The key worker scheme was being rolled out at Leicester at around this time and the officer had only just been allocated as Mr Mellor's key worker when he saw him. A keyworker is a prisoner's first point of contact and they assist prisoners with any difficulties they have in prison. There is an expectation that the keyworker will spend 45 minutes with the prisoner every week and have meaningful conversations.) Mr Mellor told the officer that he was happy working in the kitchens, that he had some mental health concerns and was frustrated with the prison's mental health team. The officer encouraged Mr Mellor to engage with the mental health team, which Mr Mellor said he would do. The officer scheduled a further meeting with Mr Mellor on 18 December.

51. The officer told the investigator that Mr Mellor was a polite and private man who attended work and seemed normal. The officer said that there was nothing noteworthy about Mr Mellor and he never caused staff any issues.

52. On 12 December, a health care support worker noted that Mr Mellor had referred himself again to the prison's mental health team and noted that Mr Mellor had written, "I'm no good at writing, I need to see someone in person. I'm not eating and not sleeping." The following day, a nurse visited Mr Mellor. He told her that he felt stressed about the possibility of having to share a cell and had problems eating and sleeping. The nurse noted that Mr Mellor had asked to see someone from the mental health team.

53. On 16 December, Mr Mellor received another visit from his friend. Intelligence indicated that he might have been passed an illicit item during the visit which he had concealed. However, nothing was found.

54. On 18 December, the key worker met Mr Mellor. He noted that he was in reasonably good spirits and had arranged an appointment with the mental health team. Mr Mellor told the officer about his risk of sharing a cell. The key worker told the investigator that Mr Mellor wanted to see the mental health team because he did not want to share a cell and wanted to be considered a high-risk prisoner because of his mental health issues. He said that Mr Mellor never spoke to him of any thoughts of suicide or self-harm. He scheduled a further meeting with Mr Mellor on 7 January 2019. (However, this meeting did not take place as the key worker was on sick leave.)

55. On 19 December 2018, a nurse assessed Mr Mellor to see if he needed a mental health assessment. The nurse noted that he was anxious and started talking about his concerns about sharing a cell with another prisoner before she had introduced herself. Mr Mellor said that he was stressed about the possibility of sharing a cell and was becoming aggressive as a result. He said that the mental health team could resolve the issue, and that his mental health problems were a

reason for him not to share a cell. Mr Mellor said that his medication was effective but that he felt low and depressed and asked whether he could have an increased dose of his medication. Mr Mellor denied thoughts of suicide and self-harm. The nurse noted that Mr Mellor had moderate depression and referred him to the GP for a review of his medication.

56. On 30 December, Mr Mellor was involved in a fight with another prisoner. His prison privileges were reviewed and he was put on the prison's basic regime for 28 days.

57. On 2 January 2019, a GP reviewed Mr Mellor's medication. He told the GP that he was worried about his upcoming trial which might result in a sentence of several years. Mr Mellor said that his antidepressants were not helping and that he would often wake in the night which made him tired during the day. Mr Mellor said that he had no issues with anyone but was worried that he might have to share a cell. He told the GP that he would "break down" every few weeks when he became overwhelmed and anxious, would cry in his cell and struggle to relax. He said that music helped to distract him. Mr Mellor said that he felt that he needed to talk to someone about his mood, thoughts and coping mechanisms as he tended to bottle things up and then "explode". The GP increased Mr Mellor's antidepressants and referred him to the mental health team and psychological wellbeing practitioner. Mr Mellor denied thoughts of suicide or self-harm.

58. A prison kitchen supervisor, told the investigator that Mr Mellor was very polite and a good worker who had his "quiet moments" but also mixed well with other prisoners, often laughing and joking with them.

59. On 7 January, the prison kitchen supervisor noticed a two-inch bruise on the back of Mr Mellor's neck and marks on his face. She said that when she asked about the marks, Mr Mellor tried to "laugh it off" and said that he had tripped on a tile in his cell and had fallen through the back of a chair. She said that she put the injury down to Mr Mellor "scrapping" with another prisoner. She said that she was unhappy with his explanation as he would not look her in the eye, and she reported it to her manager.

60. The manager asked Mr Mellor about the marks. He repeated that he had got the marks from falling into a chair. She submitted an intelligence report in which she said that she did not believe Mr Mellor's explanation, and put his injures down to a scuffle that he had been involved in a few days earlier.

61. On 10 January, Mr Mellor was interviewed by police. His solicitor was present. Mr Mellor was asked about allegations that he had perverted the course of justice in relation to the charges for which he was being held on remand. One of the police officers told Mr Mellor that he had lost weight. Mr Mellor told the officer that he had lost a couple of stones.

62. Mr Mellor was unable to attend an appointment with a psychological wellbeing practitioner (PWP), to discuss the psychosocial support and other services available at the prison because it was at the same as the police interview. She re-booked an appointment for the following week. (Mr Mellor was not told that the appointment had been re-booked.)

63. The prison kitchen supervisor told the investigator that Mr Mellor worked in the kitchens as normal on 11 January and described it as a normal day. She said that she recalled Mr Mellor and another prisoner, “mucking around and laughing”. She said that Mr Mellor appeared to be in an “upbeat” mood.

### Events of 12 January

64. On 12 January, Mr Mellor went to work in the kitchens as usual at around 9.00am. A kitchen supervisor, told the investigator that Mr Mellor worked hard and recalled that he was extra “funny” that day, mimicking members of staff and “cracking jokes”. At around 11.15am, Mr Mellor helped served lunch. The kitchen supervisor said that at about 11.45am, Mr Mellor said that he needed to go to the toilet and left the servery. He said that the next thing he knew was that Mr Mellor had changed from his kitchen work clothes and collected his lunch, although he was expected to work until around 12.30pm. He asked Mr Mellor if he was working in the afternoon. Mr Mellor said that he was.

65. The kitchen supervisor told the investigator that since Mr Mellor’s death he had heard that one of the prisoners, who went through the servery at about the time Mr Mellor left, had mentioned that someone had drugs. He suggested that Mr Mellor might have picked up on what was said and left the servery to get them.

66. A nurse told the investigator that, although she could not recall with certainty, she thought that Mr Mellor might have asked her about his missed PWP appointment at the medication hatch over the lunch period. The nurse said that she and Mr Mellor shared a joked and laughed at the time.

67. An officer who was on duty at the medication hatch, told the investigator that she recalled Mr Mellor telling her he did not feel well and wanted some paracetamol tablets. The officer said that she asked a nurse who gave him the tablets. The officer told the investigator that Mr Mellor was his usual self and raised no concerns with her.

68. A friend of Mr Mellor who occupied a cell opposite Mr Mellor’s, said that Mr Mellor collected his lunch and went back with him to his cell. He said that Mr Mellor told him that he was not working that afternoon and would catch up with him later. Mr Mellor was then locked behind his cell door at around 11.55am.

69. At around 12.17pm, an officer carried out the first of two roll checks. A second officer carried out a further check at 12.30pm. Neither officer reported any concerns after checking on Mr Mellor.

70. At around 1.47pm, an officer unlocked Mr Mellor’s cell so that he could go to work. She went briefly into the cell to call Mr Mellor before leaving. The officer told the investigator that when she left the cell, she went back in because she thought that something was not right. When she went back in and approached the bottom bunk, she could see a green ligature, made of bed sheets, around Mr Mellor’s neck and tied to his leg, which was hanging off the side of the bed. The officer called a medical emergency code blue (indicating that a prisoner is unconscious or having difficulties breathing) and an ambulance was called.

71. A second officer who was nearby arrived within seconds and cut the ligature, with the officers’ help. The two officers moved Mr Mellor to the floor of the cell and an officer checked for signs of life. There were none. A third officer who had also

arrived at the cell started cardiopulmonary resuscitation. A fourth officer helped her.

72. Within a minute of the alarm being raised, a nurse arrived at the cell, followed by another nurse who brought with her an emergency response bag. The nurses took the lead in trying to resuscitate Mr Mellor. They attached a defibrillator but it could not detect any electrical rhythm and advised no shock. The nurses continued in their attempts to resuscitate Mr Mellor until paramedics arrived at 1.54pm, and took over his care. Shortly afterwards, the paramedics detected a pulse. Mr Mellor was stabilised and at 2.21pm, he was taken to the hospital, where he died the next day.

### Contact with Mr Mellor's family

73. On 12 January, the Head of Safer Custody, arranged for Mr Mellor's parents to be contacted and told that their son had been admitted to hospital that afternoon. Members of Mr Mellor's family were present when he died the following afternoon. Leicester contributed to the costs of Mr Mellor's funeral in line with national guidance.

### Information received after Mr Mellor's death

74. Intelligence submitted after Mr Mellor's death suggested that he used PS but had not been seen under the influence of illicit substances at Leicester. Another intelligence report suggested that prisoners working in the kitchens had mentioned marks on Mr Mellor's neck and had made comments about him "trying before but failing".

75. A few days after Mr Mellor's death, further intelligence received from a prisoner alleged that Mr Mellor had been dealing in illicit drugs and that many prisoners would not be bothered that he had died, but only that they would not be able to get their drugs and phones. It was also alleged that Mr Mellor used PS at night. It was said that he would stand on a chair at his cell window to smoke it, and that quite often prisoners would hear him fall off the chair. It was also alleged that on the day of the incident, he was given PS by another prisoner.

76. A friend of Mr Mellor's told the investigator that Mr Mellor was a mature, happy man, with a strong personality and good family ties. He said that two or three days before his death, Mr Mellor had told him he had tripped in his cell and fallen into his chair, causing a mark on his neck, and he had thought nothing further of it. However, he told the investigator that looking back, this might have been an attempt by Mr Mellor to harm himself. He said that you could not see the mark on Mr Mellor's neck because he had a very big beard and he only knew of it because Mr Mellor had shown him. He said that Mr Mellor's death was a total shock and was "out of the blue".

77. A prisoner, described Mr Mellor as strong minded and someone who kept to himself. The prisoner said that he never heard Mr Mellor talk of self-harm. He said that he saw Mr Mellor briefly just before the cells were locked and although he did not speak to him, he said that he looked the same as normal. He said that he thought that Mr Mellor might have smoked PS but he never saw him under the influence on the wing. He said that he was "baffled" by what Mr Mellor had done.

78. A second prisoner, said that Mr Mellor was calm, mixed well with others and that there was no change in his personality in the days leading to his death. He said that when he had worked with Mr Mellor in the kitchens on the morning of 12 January, Mr Mellor had “mucked around and bantered” with other prisoners as normal. He said that he was shocked to learn of Mr Mellor’s death.

79. A third prisoner, said that Mr Mellor did not seem to have a problem with anyone. He told the investigator that a few days before Mr Mellor’s death, he had seen a “red line” around his neck, like a ligature mark, and a mark on his face. He said that you could not miss the mark on Mr Mellor’s neck as his beard did not hide it. He said that Mr Mellor had told him that he had had a fit and fallen into a chair in his cell. He said that he doubted the explanation. He had not told staff about this.

### Support for prisoners and staff

80. The Head of Safer Custody, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.

81. The Governor issued notices to staff and prisoners informing them of Mr Mellor’s death. Staff reviewed prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Mellor’s death.

### Post-mortem report

82. A post mortem examination found that Mr Mellor died of a hypoxic/ischaemic brain injury (a brain injury as a result of a lack of oxygen to the brain) sustained following the application of a ligature to the neck. Toxicology tests detected traces of mirtazapine at therapeutic levels and that Mr Mellor had used PS before his death. The pathologist concluded that Mr Mellor’s mental health may have been affected by using PS but its presence had not directly caused or contributed to his death.

# Findings

### Identifying risk of suicide and self-harm

83. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm, and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk.

84. Although Mr Mellor had a history of self-harm, none of the prison staff whom we interviewed at Leicester considered that he was at risk of suicide or self-harm during his time at the prison. Although, with hindsight, it is possible that the marks on Mr Mellor's neck were caused by self-harm, he did not have a known recent history of self-harm, he had not been monitored under ACCT procedures since February 2016 and even Mr Mellor's friends were surprised by the actions he took (although some thought that the marks around his neck might not have been sustained by accident or a fight but from an act of self-harm). Although staff questioned the marks on Mr Mellor's neck, it was reasonable without the benefit of hindsight that they did not link them to self-harm.

85. We are satisfied that while Mr Mellor was at Leicester, including in the days before his death, he gave no indication to prison staff that he was at risk of suicide. Although there were several missed opportunities, where concerns about his risk to self-harm might have been identified, we do not consider that prison staff could reasonably have predicted his actions given the information available to them at the time.

### Psychoactive substance availability at Leicester

86. Although Mr Mellor's substance misuse did not directly contribute to or cause his death, he had used PS sometime before he died. PS can have a very negative effect on mood and mental health.

87. In their recent inspection report, HMIP noted that PS remained a threat to stability at Leicester and although there were good initiatives to address the issue, efforts to reduce the supply of drugs were not effective enough. HMIP made a recommendation to reduce the supply of drugs at Leicester,

88. Mr Mellor had a history of PS misuse during previous periods of prison custody, although there was no intelligence to suggest that he was using them at Leicester. However, intelligence at Leicester suggested that he might have been passed illicit items during a visit (although no illicit substances were found when Mr Mellor was searched afterwards).

89. Leicester has a substance misuse strategy, which was issued in June 2018, and holds monthly drug strategy meetings. The substance misuse strategy aims to provide a safe, drug-free environment and to address substance misuse, prevention, treatment, education and effective communication with the community. Leicester continues to try to prevent PS getting into the prison,

including by testing prisoner mail for impregnated PS and increased surveillance of the prison's perimeter wall during prison visits.

90. Although we are satisfied that Leicester continue to make efforts to challenge the availability of and demand for PS at the prison, Mr Mellor appears to have had no difficulty in obtaining and using PS without staff becoming aware. It is therefore clear that more needs to be done to reduce both the supply and demand for PS.

91. Drug taking and trading is a severe problem across much of the prison estate and Leicester is not alone in facing this problem. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies, as Leicester has. However, the PPO has called for national guidance to prisons from HMPPS on providing evidence-based advice on what works to reduce the supply and demand of drugs, including PS in prisons.

92. This recommendation was accepted and in April 2019 a National Drug Strategy, developed by the Ministry of Justice and HM Prison and Probation Service, was published setting out their plans to reduce the misuse of drugs in prisons by providing direction to assist all stakeholders and to release detailed guidance for prisons to support them in identifying issues and to share best practice.

93. In relation to reducing the supply of drugs, the new Prison Service strategy says:

> "Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

94. We therefore recommend that:

**The Governor should ensure that the key drug issues at Leicester are identified and that the prison's local drugs strategy is revised by September 2019 to address these issues.**

### Communication of changes in behaviour and assessment after police interview

95. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners says that events such as attending court, sentencing at court or being questioned by police might have a significant impact on a prisoner's health.

96. On 10 January, police interviewed Mr Mellor about allegations of perverting the course of justice. However, despite these serious allegations, there is no evidence that anyone at the prison spoke to Mr Mellor after his police interview to assess whether his risk of suicide or self-harm had increased as a result of the interview, or that the healthcare team assessed him, as would have happened if he had attended court. We were told that there is no routine assessment for prisoners after a police interview.

97. This was a missed opportunity to identify if Mr Mellor's risk had increased. We note that on the morning that Mr Mellor was found, he had been concerned about missing his psychosocial assessment appointment with the psychological wellbeing practitioner. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that prisoners returning from police questioning, court appearances or other temporary absences are screened to assess their risk of suicide or self-harm.**

### Clinical care

98. The clinical reviewer, concluded that the care that Mr Mellor received was not equivalent to that which he could have expected to receive in the community.

#### *Care plans*

99. The clinical reviewer was concerned that after a nurse reviewed Mr Mellor on 3 September, she did not develop a care plan going forward and had not record any care plan in Mr Mellor's clinical record, although she said in interview that she had planned for him to be allocated a health care support worker to provide occasional emotional support. In addition, the nurse did not make any plans or arrangements for Mr Mellor to be followed up after her review. Similarly, no clear care plan was recorded after the mental health team saw Mr Mellor on 16 December.

100. The clinical reviewer concluded that the mental health services at the prison should have formulated a care plan to manage Mr Mellor's level of risk based on an overall assessment of everything that made him anxious. We agree with the clinical reviewer's findings and make the following recommendation:

**The Head of Healthcare should ensure that all healthcare staff reviewing or assessing prisoners make accurate notes of their interactions and record care plans and other actions clearly.**

#### *Returned mental health self-referral*

101. On 31 October, Mr Mellor referred himself to the prison's mental health team and asked to be seen by a specific mental health nurse. However, the referral was returned to Mr Mellor as the nurse he had asked to see no longer worked at the prison. Mr Mellor was asked to submit a further referral, setting out his needs. The psychological wellbeing practitioner who retuned the referral said that she did not usually triage referrals to the mental health team. She said that she returned the referral to seek further information from Mr Mellor so he could be signposted to the correct services for his condition. (Mr Mellor did not make a further self-referral until 12 December.)

102. We consider that this was a missed opportunity for mental health staff to have further identified Mr Mellor's mental health needs, especially as a nurse had not made a plan for him on 3 September. A member of the mental health team should have seen him in person to establish his needs. The onus should not be placed on prisoners to submit a second referral if their reasons for referral are not clear. We make the following recommendation:

103. **The Head of Healthcare should ensure that when prisoners refer themselves to the mental health team, mental healthcare staff do not return incomplete or unclear applications without first assessing the urgency of and reasons for the referral.**

### *Not being told of cancelled PWP appointment after police interview*

104. Mr Mellor missed his appointment with the psychological wellbeing practitioner to discuss psychological support because it was at the same time as his police interview. Although a further appointment was made for the following week, he was not told about the new appointment. The psychological wellbeing practitioner said that Mr Mellor would not have been told about the appointment until the night before. We make the following recommendation:

    **The Head of Healthcare should review the system for notifying prisoners of rearranged appointments for their clinical services and consider early notification to alleviate anxiety about missed appointments.**

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